Welcome to Abbott Family Dentistry LLC

Robert P. Pierson, DDS

PATIENT INFORMATION:

NAME: ______________________________ SSN: ______________

MAILING ADDRESS: ______________________________ BIRTHDATE: ______________

CITY: ______________ STATE: ____ ZIP: __________ DRIVER'S LICENSE: ______________

PHYSICAL ADDRESS: ______________________________ HOME PHONE: ______________

IF SAME AS MAILING, WRITE "SAME"

EMPLOYER: ______________________________ OCCUPATION: ______________

ADDRESS: ______________________________ WORK PHONE: ______________

CITY: ______________ STATE: ____ ZIP: __________ CELL PHONE: ______________

AT WHICH NUMBER WOULD YOU LIKE US TO CONTACT YOU: ______________

CAN WE LEAVE PRIVATE HEALTH INFORMATION ON YOUR VOICEMAIL: ______________

We will call you at the preferred number 2 days before your appointment to confirm.

In addition, as a courtesy, we can also notify you via text and/or e-mail. Please provide that information below:

CELL: ______________ CARRIER: __________ E-MAIL: ______________

IF YOU ARE A FULL-TIME STUDENT LIST UNIVERSITY & CITY: ______________

WHOM CAN WE THANK FOR REFERRING YOU TO OUR OFFICE: ______________

GUARANTOR: (PERSON RESPONSIBLE FOR PAYMENT) IF SAME AS ABOVE, WRITE "SAME"

NAME: ______________________________ SSN: ______________

ADDRESS: ______________________________ BIRTHDATE: ______________

CITY: ______________ STATE: ____ ZIP: __________ DRIVER'S LICENSE: ______________

EMPLOYER: ______________________________ OCCUPATION: ______________

ADDRESS: ______________________________ WORK PHONE: ______________

CITY: ______________ STATE: ____ ZIP: __________ CELL PHONE: ______________

SPOUSE INFORMATION: IF SAME AS GUARANTOR, WRITE "SAME"

SPOUSE'S NAME: ______________________________ SSN: ______________

ADDRESS: ______________________________ BIRTHDATE: ______________

CITY: ______________ STATE: ____ ZIP: __________ DRIVER'S LICENSE: ______________

SPOUSE'S EMPLOYER: ______________________________ OCCUPATION: ______________

ADDRESS: ______________________________ WORK PHONE: ______________

CITY: ______________ STATE: ____ ZIP: __________ CELL PHONE: ______________

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PRIMARY INSURANCE:

INSURANCE COMPANY: ______________________________ PHONE: ______________

GROUP NUMBER: ______________ I.D. NUMBER (OR SSN): ______________

NAME OF SUBSCRIBER: ______________________________ BIRTHDATE: ______________

SECONDARY INSURANCE:

INSURANCE COMPANY: ______________________________ PHONE: ______________

GROUP NUMBER: ______________ I.D. NUMBER (OR SSN): ______________

NAME OF SUBSCRIBER: ______________________________ BIRTHDATE: ______________

ASSIGNMENT AND RELEASE:

I CERTIFY THAT I, AND/OR MY DEPENDENT(S), HAVE INSURANCE COVERAGE WITH ______________ AND THAT I AUTHORIZE THE USE OF MY SIGNATURE ON ALL INSURANCE CLAIMS SUBMITTED AND ASSIGN DIRECTLY TO DR. ROBERT P. PIERSON, AND/OR Abbott Family Dentistry LLC, ALL INSURANCE BENEFITS, IF ANY, OTHERWISE PAYABLE TO ME FOR SERVICES RENDERED. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY INSURANCE. I HAVE RECEIVED A COPY OF THE NOTICE OF PRIVACY PRACTICES FOR THIS OFFICE AND GIVE MY CONSENT FOR THE USE AND DISCLOSURE OF MY PROTECTED HEALTH INFORMATION TO CARRY OUT TREATMENT, PAYMENT ACTIVITIES, AND HEALTHCARE OPERATIONS. I AUTHORIZE AND GIVE CONSENT FOR DR. ROBERT P. PIERSON, AND/OR Abbott Family Dentistry LLC, TO CONTACT MY EMPLOYER TO VERIFY EMPLOYMENT AND ANY OTHER INFORMATION NEEDED TO VERIFY INSURANCE ELIGIBILITY AND BENEFITS.

SIGNATURE______________________________ DATE______________